Choosing the correct wound care dressing: an overview

Linda Nazarko

Almost one adult in 20 in the UK has a wound, while the NHS cares for 2.2 million people with wounds annually. Most of the people in the UK with a wound are managed in primary care by nurses (Guest et al, 2015). Some wounds, such as minor burns, cuts, abrasions and surgical wounds, heal quickly and with minimal intervention. However, over half of all wounds go on to become chronic, with approximately 39% of these failing to heal after 12 months (Vowden and Vowden, 2009). One of the basic tenets of evidence-based wound care is choosing the correct dressing. This article discusses the management of chronic wounds in the community and provides guidance for community nurses on choosing appropriate dressings.

KEYWORDS:
- Chronic wounds
- Dressing choice
- Evidence-based care

Chronic wounds have been defined as those ‘which have failed to proceed through an orderly and timely reparative process to produce anatomic and functional integrity over a period of three months’ (Mustoe et al, 2006). The cost of managing people with chronic wounds is rising. In 2008, Posnett and Franks (2008) estimated that the cost of caring for people with chronic wounds was around £2.3-3.1bn a year, while in 2015, Guest et al (2015) estimated that these costs had risen to £4.5bn annually.

Adults aged 65 and over are more likely to have comorbidities such as diabetes, heart disease and venous and arterial diseases that affect wound healing (Rüttermann et al, 2013; Gould et al, 2015). As the UK population ages (Figure 1), the number of people with comorbidities that affect wound healing is set to rise. Each year, community nurses care for 730,000 people with leg ulcers, 169,000 people with diabetic foot ulcers and 153,000 people with pressure ulcers (Guest et al, 2015). Only 278,000 of those with leg ulcers have a formal diagnosis of a venous ulcer — the others remain unclassified. This data also excludes people living in care homes (Guest et al, 2015). With these figures set to rise due to an ageing population (Office for National Statistics, 2014), it is vitally important that community nurses are able to manage chronic wounds by providing holistic evidence-based care (Mahoney, 2014).

On average, it costs 135% more to treat chronic wounds, so it is important to focus on prevention, diagnosing the cause of wounds that do not progress, and improving wound-healing rates (Guest et al, 2017). Choosing an appropriate dressing for a patient’s wound will enable it to heal more quickly and improve patient quality of life (Guest et al, 2012; National Institute for Health and Care Excellence [NICE], 2016a, 2018).

HOLISTIC ASSESSMENT

It is important to undertake comprehensive holistic assessment of a patient with a wound and, where possible, to address factors affecting wound healing. These can be both intrinsic (internal) and extrinsic (external). Some factors, such as poorly controlled diabetes mellitus, may be modifiable, whereas others, such as age, are non-modifiable.
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Intrinsic factors
Ageing affects the structure and function of the skin. Older skin is at greater risk of damage and takes longer to heal (Meyers and Hudson, 2013; Nigam and Knight, 2017), and thus needs protecting from damage (Wounds UK, 2012).

Poorly controlled diabetes can lead to neuropathy, which impairs sensation and increases the risk of skin damage as the person does not feel pain, and micro- and macrovascular complications, which can delay wound healing (Guo and DiPietro, 2010; International Best Practice Guidelines, 2013).

Poor nutrition affects wound healing, as patients with wounds require additional calories for healing (Bishop et al, 2018). Healing also requires sufficient protein and vitamins, as well as trace elements, such as iron and zinc (Guo and DiPietro, 2010). People with exuding wounds may also lose a significant amount of protein in exudate.

Other intrinsic factors can be psychosocial, such as stress, or include diseases such as renal disease and rheumatoid arthritis, for example.

Extrinsic factors
Cigarette smoking increases the risk of cardiac and respiratory disease, impairs wound healing and increases the risk of infection (Cope, 2014). Excessive alcohol consumption also impairs wound healing (Tønnesen et al, 2012). Medication can affect wound healing, for example, cytotoxic medicines impair healing and increase infection risks. Medication that reduces the inflammatory response, such as non-steroidal inflammatory drugs (NSAIDS) and steroids, can also delay healing (Anderson and Hamm, 2012).

To facilitate effective wound healing, community nurses should work with other members of the multidisciplinary team, including dieticians, physiotherapists, nurse specialists, GPs and hospital consultants, to ensure that patient comorbidities are effectively managed.

WOUND ASSESSMENT
It is important to gather objective data about the wound (Gethin, 2007; Ousey and Atkin, 2013). This enables the nurse to determine what type of wound the person has, its size, condition of the wound bed, characteristics of any exudate being produced and the level of pain the person is experiencing.

The TIME concept (relating to tissue, infection/inflammation, moisture balance and edge of wound) provides a framework for a structured approach to wound bed preparation which will, in turn, optimise wound management (Schultz et al, 2003). Dowsett et al (2015a,b) expanded the TIME framework with guidance that included treatment of the skin beyond the edge of the wound.

Classification
Using a simple system to classify tissue type present in wounds can help nurses to choose the most appropriate treatment (Table 1).

AETIOLOGY
The most common chronic wounds encountered in community practice are leg ulcers, diabetic foot ulcers and pressure ulcers. However, Guest et al (2015) found that in 30% of cases studied, the type of wound had not been diagnosed and only 16% of patients with a leg or foot ulcer had an ankle-brachial pressure index (ABPI) measurement taken.

Through comprehensive holistic assessment, nurses should determine why a wound has developed, as well as why it has failed to heal, so that they can provide treatment to address the cause(s) (Wounds UK, 2016).

ABPI measurement enables nurses to determine if the patient’s blood flow is normal or reduced. The latter is indicative of arterial disease and may require specialist vascular review. Although ABPI measurement will not diagnose venous leg ulceration (Wounds UK, 2016), it will determine if the wound has been caused by venous or arterial problems, or both, and so guide treatment choice.

Venous leg ulcers
A chronic venous leg ulcer has been defined as ‘an open lesion between the knee and the ankle joint that remains unhealed for at least four weeks and occurs in the presence of venous disease’ (Scottish Intercollegiate Guidelines Network [SIGN], 2010). Venous leg ulcers mainly arise as a result of chronic venous insufficiency (CVI) and treatment should aim to improve venous circulation (Franks et al, 2016). Table 2 illustrates the clinical features of leg ulcers.

Pressure ulcers
A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, which develops as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors, such as age, hypertension, chronic obstructive airways disease and anaemia, are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance [NPUAP/EPUAP/PPPIA], 2014).

Pressure ulcers are classified according to the depth of tissue damage sustained and may be referred to as stage or category 1–4 (Table 3). Two further stages, unstageable and suspected deep tissue pressure injury (DTPI; depth unknown), were adopted by the USA in 2009 and integrated into the latest guidelines (NPUAP, 2016).
**Table 1: Classification of wound tissue types**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description of wound bed</th>
<th>Aims of treatment</th>
<th>Management</th>
</tr>
</thead>
</table>
| Necrotic       | Black hard necrotic eschar| To remove devitalised tissue and facilitate wound healing | ‣ Hydrogel with film dressing  
‣ Hydrocolloid dressing  
‣ Larval therapy with secondary dressing  
‣ Mechanical, hydrosurgical and/or surgical debridement |
| Sloughy        | Covered with yellow sloughy tissue | To remove devitalised tissue and facilitate wound healing | ‣ Debridement pad  
‣ Iodine dressings and pastes  
‣ Hydrocolloid dressing  
‣ Hydrofiber dressing  
‣ Alginates dressing  
‣ Honey  
‣ Larval therapy |
| Granulating    | Red or deep pink. These wounds are filled with granulation tissue | To protect the wound bed while healing takes place | ‣ Alginates, cut to size of wound, with a secondary dressing  
‣ Hydrocolloid, foam or film dressings |
| Epithelialising| Superficial wound with clean, pink or white tissue. Pink or white margin to wound, pink islands on surface of wound | To protect the wound bed while healing takes place | ‣ Hydrocolloid, foam or film dressings |

**Diabetic foot ulcers**

Diabetic foot ulcers arise because of nerve damage (neuropathy), reduced blood flow to the lower limb (ischaemia), or a combination of both (neuroischaemia). *Figure 2* details the classification of diabetic foot ulcers (James, 2008). Due to a risk of rapid deterioration and subsequent amputation, patients with diabetic foot ulcers should be referred to a multidisciplinary foot care team within 24 hours of diagnosis (Kerr, 2012; NICE, 2016b).

**WOUND HEALING**

**History**

In the past, it was considered important to keep wounds healing by secondary intention clean and dry. In 1962, George Winter’s research proved that wounds covered with an occlusive dressing healed twice as fast as those that were allowed to dry out (Winter, 1962).

In the 1970s, Lock found that cooling a wound reduced the rate of healing (Lock, 1980), while in the 1980s, researchers compared healing rates of wounds left exposed, wounds covered in gauze-soaked in saline, wounds covered with a film dressing and wounds covered with a hydrocolloid dressing (Alvarez et al, 1983). Those covered with a hydrocolloid dressing healed fastest, followed by those covered with a film, those soaked in saline, and, finally, those that had been left exposed. The various rates of wound healing were due to oxygen tension. Occlusive dressings, such as hydrocolloid and film dressings, create a very low oxygen tension, which leads to high levels of oxygen at the capillaries and low levels of oxygen at the wound edges. This provided the ideal environment for wound healing, as it stimulated granulation (Alvarez et al, 1983).

Later, and as mentioned above, the TIME concept was developed by an international group of wound healing experts to provide a framework for a structured approach to wound bed preparation and to optimise wound management (Schultz et al, 2003).

**Principles of wound healing**

Wounds heal in two distinct ways, primary and secondary intention. Surgical wounds and those where the edges of the wound are pulled together by sutures, glue, staples or adhesive strips, heal by primary intention. The body only needs to produce a small amount of tissue to promote wound healing and primary healing is completed within days.

A wound extending into the dermis or deeper tissues resulting in greater loss of tissue, for example pressure or venous leg ulcers, heal by secondary intention through granulation and epithelialisation (Brown, 2015). This tissue must be replaced with new tissue and, finally, covered with epithelium. Secondary healing can take weeks or months depending on the site and size of the wound (intrinsic factors), and the nutritional status, health status and age of the individual (extrinsic factors).

Wound healing consists of three phases that overlap (Leaper and Harding, 1998; Stacey, 2016):
cytokines. Cytokines stimulate fibroblasts. Macrophages also secrete growth factors to stimulate the formation of new tissues. T-lymphocytes then migrate into the wound around 72 hours after injury. They secrete growth factors and antibodies. This occurs following haemostasis and lasts 1–4 days.

- Proliferation phase: this begins around 3–5 days after injury when granulation tissue is formed. Granulation tissue includes inflammatory cells, fibroblasts, and the formation of new blood vessels.

- Maturation phase: this can go on for 21 days up to two years, and occurs once the wound has closed. It involves remodelling of collagen and regression and decrease in blood vessels.

As said, although distinct phases, they do not take place in isolation, and can overlap one another.

**Healing in practice**

In chronic wounds, there are variations in the wound healing process, dependent on the patient and wound presentation. Thus, it is important to care for the whole person, not just the wound, as factors relating to the person’s general health may have led to the development of the wound, or may be impeding healing (Figure 3).

If, for example, the patient has a pressure ulcer, this may have developed as a result of malnutrition, poor mobility and urinary or faecal incontinence, as well as pressure itself. The patient may require a special bed that can be raised and lowered to improve ease of transfer from the bed and to accommodate the pressure-relieving mattress, a pressure-relieving mattress and seating cushion, and input from physiotherapy and occupational therapy to improve a person’s ability to turn over in bed, to change position when seated and the ability to walk. The patient may also require assistance with personal care, such as washing, dressing and help using the toilet or commode.

### Table 3: Classification of pressure ulcers (adapted from NPUAP/EPUAP/PPPIA, 2014)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin</td>
</tr>
<tr>
<td>2</td>
<td>Partial-thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister</td>
</tr>
<tr>
<td>3</td>
<td>Full-thickness skin loss involving damage to subcutaneous tissue that may extend down to, but not through, underlying fascia</td>
</tr>
<tr>
<td>4</td>
<td>Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures, with or without full-thickness skin loss</td>
</tr>
</tbody>
</table>

- Unstageable: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a stage 3 or stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischaemic limb should not be softened or removed.

- Deep tissue pressure injury (DTPI): Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures, with or without full-thickness skin loss.

**History**

- Immobility, loss of sensation, incontinence

**Position**

- Over a bony prominence

**Edges**

- Variable

**Wound bed**

- Variable dependent on grade

**Exudate**

- Variable dependent on grade

**Pain**

- Variable dependent on grade

**Skin**

- May be intact or present as a blister or a wound

**Investigation**

- Determine mobility, continence and nutritional status and other predisposing factors

**Treatment**

- Reduce pressure, improve mobility, manage any continence issues and use appropriate dressings

- **Deep tissue pressure injury (DTPI):** Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures, with or without full-thickness skin loss.

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### Inflammatory phase

Blood flow to the wound increases and neutrophils, macrophages, and lymphocytes act to promote healing. Neutrophils predominate in the first 48 hours following injury. They cleanse the wound site of bacteria and necrotic matter and release inflammatory mediators and bactericidal oxygen free radicals. Macrophages are essential to wound healing and are the most important cells in the early phase. Macrophages engulf and destroy debris and bacteria, and secrete collagenases and elastases, which break down injured tissue and release...
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Hydrogel products prevent water evaporating from the necrotic tissue and promote rehydration. The glycol softens the necrotic tissue and the water in the gel is absorbed by the necrotic tissue, causing it to soften, which aids autolytic debridement (Thomas and Hay, 1996). Hydrogel products such as Intrasite® Gel (Smith and Nephew) and Granuflex® hydrocolloid gel (Convatec) are applied to the wound underneath a secondary dressing.

When wounds are very dry, film dressings, such as Opsite® (Smith and Nephew) or Tegaderm® (3M), can prevent evaporation and moisture loss.

Hydrocolloid dressings, such as Granuflex® (Convatec) and Comfeel® Plus Transparent (Coloplast), prevent water loss from the dry wound bed enabling the wound to rehydrate.

Other debridement techniques include (Gray et al, 2011):

- Hydrosurgery (also known as jet lavage): this uses sterile water delivered at high pressure to wash away dead tissue. It can be combined with sharp debridement (Strohal et al, 2013; Gray et al, 2011). This system requires specialist training.
- Mechanical: traditional methods of removing dead tissue with wet or dry gauze are now considered to be potentially harmful (Vowden and Vowden, 2011). Newer methods include active debridement pads (such as Debrisoft®, L&R) which use a fleece-like contact layer to mechanically remove debris, necrotic tissue, slough and exudate (Gray et al, 2011). This has been shown to be effective in 94% of cases in patients treated on three occasions, approximately four days apart (Bahr et al, 2011). The UCS™ debridement cloth (medi UK), a pre-moistened, single-use cloth, can also be used to debride wounds. It has a mild cleansing agent that moisturises and softens the skin (Downe, 2014). Both products can be used by non-specialists and are available on FP10 prescription.
- Sharp: this involves the removal of dead tissue with a scalpel, pair of scissors or forceps. It can only be performed by trained and competent clinicians. It is a fast, selective and effective means to remove devitalised tissue and is rarely painful.
- Ultrasonic: low-frequency, low-dose ultrasound has been found to break down dead tissue. There are two manufacturers (Sonoca™, Soring; MIST™ Therapy, Celleration Inc). The Sonoca device delivers ultrasound.

**Practice point**

Wounds heal most effectively in a warm, moist environment with low levels of oxygen tension. If there are concerns regarding blood supply to a wound, nurses should remember the maxim, ‘if there’s no blood supply keep it dry’ and seek expert advice.
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directly, while MIST uses a mist spray that helps wash out the wound as it is debrided. These methods are painless and reduce bacterial burden, however several treatments are required (Strohal et al, 2013). Ultrasound treatments are usually delivered in hospital and require specialist training.

Larval therapy is another method of debridement. Indeed, larvae of the greenbottle fly (Lucilia sericata) have been used to treat infected, gangrenous and necrotic wounds for thousands of years. Before antibiotics were discovered, larvae were used to clean battlefield wounds (Church, 1996).

The benefit of larval therapy is that the larvae liquefy and ingest slough and necrotic tissue, but do not feed on living tissue. The larval secretions also destroy Streptococcus and Staphylococcus bacteria (Thomas et al, 1999). While larval therapy was seldom used after the 1940s, when antibiotics were discovered, it rose to prominence again in the UK in the 1980s as a result of concern about growing levels of antibiotic resistance. Larvae were originally available in small containers and applied directly to the wound, however, they are now available in mesh biobags, which contain the larvae while allowing them to feed on the necrotic tissue. One in vivo study compared the use of hydrogel dressings with larvae in biobags and free-range maggots (Dumville et al, 2009). Researchers found that it took 72 days to debride a wound using hydrogels, 28 days using larvae in biobags, and 14 days using free-range larvae.

There are no UK national guidelines on the use of larvae, however, the All Wales Tissue Viability Nurse Forum (2013) have produced a useful guide.

**Sloughy wounds**

Slough is a mixture of fibrin, protein, serous exudate, leucocytes and bacteria. Slough slows the healing process and makes the wound more vulnerable to infection (Falabella, 2006). Removing slough helps the wound to heal quickly and reduces the risk of infection (Gethin et al, 2015). Treatment options available for removing slough include debridement pads and cloths, iodine dressings, hydrocolloids, alginates, honey-impregnated dressings and larval therapy.

As said, debridement pads can be used to remove debris and devitalised sloughy tissue from the wound bed quickly and effectively without causing trauma to the patient (Bahr, 2011).

Iodine beads (contained in Iodoflex® dressings [Smith and Nephew]) or ointment (Iodosorb® Gel [Smith and Nephew]) contain iodine that can be absorbed systemically, as the dressings are applied directly to the wound bed. This therapy can affect the patient’s thyroid function, however, and no more than three tubes of ointment should be used across a seven-day period. Patients should be tested for iodine sensitivity beforehand (Vermeulen and Ubbink, 2010).

Alginate dressings, such as Kaltostat® (Convatec) and Sorbsan® (Aspen Medical), can be used on moderately exuding sloughy wounds. They should not be used on dry or necrotic wounds. Alginate dressings are manufactured from seaweed and form a gel as they absorb exudate from the wound. This gel prevents the slough from drying out and enables the body to break it down. Alginites should be cut or folded to the shape of the wound to prevent maceration of surrounding skin and a secondary dressing is required (British National Formulary [BNF], 2018).

Hydrocolloid dressings can also be used on sloughy wounds, which are not producing a large volume of exudate. Hydrofiber® wound dressings, made of carboxymethylcellulose fibres, lock exudate into the dressing fibres and protect the surrounding skin from maceration. These dressings gel on contact with wound fluid. The gel immobilises bacteria and removes excess moisture from the wound (Robinson, 2009; Walker et al, 2003). Hydrofiber dressings are available with and without silver (such as, AQUACEL® AG and AQUACEL® [ConvaTec]).

Medical grade honey contains polysaccharides that help remove debris from the wound. Honey has antimicrobial and anti-inflammatory properties and has been used clinically for both acute and chronic wounds (Stephen-Hayes, 2011). It is available in a variety of products, such as tubes of honey ointment, honey-impregnated tulles, alginates, gels and meshes. Medical grade honey can also help to control wound malodour (Akmetova et al, 2016). Gethin et al (2015) found evidence that ulcers debrided with honey were more likely to heal than those debrided with hydrogels.

Some patients are unable to tolerate honey dressings, however, as they find them uncomfortable or painful. This may be due to their osmotic properties. Honey dressings should not be used on patients with extreme sensitivity to honey, bee stings or bee products. Patients with diabetes should be monitored for changes in blood-glucose concentrations during treatment with topical honey or honey-impregnated dressings.

Larval therapy also removes slough from wounds and, as the larvae move across the wound, they also stimulate the formation of granulation tissue.

**Granulating wounds**

Granulating wounds have a good blood supply and are red or deep pink. This suggests that the wound is healing. However, the wound still requires careful management, as wounds can get stuck at any stage of the healing process. Granulating wounds may be small or large, deep or shallow. Dressing choice is dictated by the size and depth of the wound. Hydrogels can be used to rehydrate a dry wound bed, while alginates maintain moisture balance in the wound. Negative pressure wound pressure therapy (NPWT) can also be used in heavily exuding wounds.
Epithelialising wounds

These wounds are usually superficial. Treatment aims to provide a moist warm environment so that wound healing can be completed. Epithelialising wounds rarely produce a large volume of exudate; therefore, hydrocolloid, foam and film dressings are usually suitable.

Cavity wounds

Here, the aim of treatment is to retain a moist wound environment while preventing excess exudate from causing maceration to the periwound skin. Treatment options include Hydrofiber and alginate dressings, and NPWT. NPWT removes excess extracellular fluid, reduces hydrostatic compression, optimises tissue perfusion, and is thought to accelerate wound healing by altering wound microvascular blood flow.

Although many studies using laser Doppler have found that NPWT increases perfusion, recent work using other modalities has demonstrated that perfusion is reduced. Shon et al (2014) investigated how NPWT affected tissue oxygenation of the foot — the most sensitive region of the body to ischaemia. They found that NPWT significantly decreased tissue oxygenation of the foot by 2.9 to 13.9mmHg, and recommended that it should be used with caution on feet that do not have adequate tissue oxygenation for wound healing. NPWT also removes slough and necrotic material and has been found to lead to closure of 93% of wounds within 5–10 weeks (Smith, 2004). Applied to the wound, NPWT facilitates wound drainage, reduces oedema and bioburden, and promotes the formation of granulation tissue (Leaper et al, 2012).

Remember, it is important to assess for any sinuses, tunneling, or undermining of the cavity under the periwound skin edge.

Diabetic foot wounds

Treatment of diabetic foot wounds involves optimising diabetic control, evidence-based wound care, treating infection and relieving pressure. Infection should be treated with appropriate antibiotics using the appropriate route — this is determined by the severity of the infection (International Best Practice Guidelines, 2013; NICE, 2016b). Wound debridement (undertaken by appropriately trained specialists) can promote accelerated healing (Edwards and Stapley, 2010).

ROLE OF TISSUE VIABILITY NURSE SPECIALISTS

It is important that organisations have clear policies that promote best practice using evidence-based guidance and that staff understand when they should seek specialist wound care input from a tissue viability nurse (TVN; and, if appropriate, a vascular surgeon). They should also ensure that all staff offer a standard approach to treatment, care and documentation. This should include incident reporting in relation to pressure ulcers and wounds. When a patient develops a pressure ulcer graded at stage 2 or above, an incident form must be completed. In most organisations, these are sent automatically to the tissue viability nursing team. The TVN should then check that all appropriate actions are in place.

CONCLUSION

Community nurses manage the care of individuals with wounds who have different preferences, lifestyles and conditions. Thus, there is no one type of dressing to suit every patient, even those with a similar type or stage of wound.

To select the most appropriate dressing/treatment, it is vital that comprehensive holistic wound assessment also considers the patient’s preferences. Healthcare professionals should always work with patients to ensure that care remains centred on the individual.

REFERENCES


